

2400 Ryan Street Lake Charles, LA 70601 Phone: (337) 990-8001 Fax: (337) 240-7661

## PROTOCOL AUTHORIZATION FORM

(REQUIRED)

MPLOYEE NAME:	PHONE:PO/JOB #:PO/JOB #:PHONE:  E-MAILOTHERCKED ITEMS ONLY****
OMPANY ADDRESS:	FAX:PO/JOB #: PHONE:  E-MAIL OTHER  CKED ITEMS ONLY****
TTY:	PHONE:  E-MAIL  OTHER  CKED ITEMS ONLY****
UPERVISORS NAME:	PHONE: E-MAIL OTHERCKED ITEMS ONLY***
MAIL  ****SERVICES RENDERED ON CHEC	E-MAIL OTHER CKED ITEMS ONLY***
****SERVICES RENDERED ON CHEC	OTHERCKED ITEMS ONLY****
****SERVICES RENDERED ON CHEC	CKED ITEMS ONLY****
WORK COMP INJURY	
	DRUG SCREEN
☐ Bill Above Named Company	□ DOT
	□ Non-DOT
	□ DOT Collection
☐ Bill Workers Comp Insurance Carrier: It is the	□ Non-DOT Collection
responsibility of the company to call in a First Report of	☐ Quick Screen
Injury (Form IA-1) to your workers' compensation insurance	□ Hair
carrier. Please provide carrier info and claim number below.	Other
	ALCOHOL TESTING
Workers Comp Insurance Carrier	
Company:	□ Non-DOT
Phone:	☐ Breath
	□ Saliva
Address:	☐ Other <b>REASON FOR TEST</b>
Adjustor:	Post Accident
City:	☐ Pre-employment
	□ Random
State:Zip:	□ Other
Claim No.:	PHYSICAL EXAMS
	□ Non DOT
Your assistance in providing the claim number for this injury will expedite the management of this injury and the processing	
of claims.	OTHER
of claims.	
<u></u>	

(PRINT NAME)